NovaHealth

❒ REQUEST FOR OTHER ORTHOPAEDIC EVALUATION ❒ REQUEST FOR SPINE CENTER EVALUATION*

❒ **InterMed Physical Therapy * Stroudwater - Fax 541-4865 ***** Yarmouth - Fax 541-4865**
❒ **Orthopaedic Assoc. of Portland * 33 Sewall St. * Portland, ME 04101 Fax 553-7192 * Ph 828-2100**

❒ Consult only ❒ Consult and manage ❒ Surgical Opinion

❒ Reason for evaluation: ____

❒ Urgent (within 48 Hours) ❒ Sub-acute (within 2 Weeks) ❒ Non-urgent

Complete this section or print and fax patient demographic screen Male ❒ Female ❒

Pt. Name: ______________________________ Today's Date: __________Patient Acct #: __________

Address: ______________________________ PCP: ______________________________

City/State: ________________ Zip Code:______ Ref. Prov.: ______________Referral:____________

Pt. Phone: (H) ______________ (W) __________ Insurance & ID#: ____________________________

Pt. Cell Phone: ________________ (Circle best # to use for Pt.) DOB: ___/___/___ SS#: __________

Workers Compensation: Yes ❒ No ❒ Date of Injury ___/___/___ Claim #: __________________

Carrier:_______________________ Adjuster: ____________________ Phone #: __________________

Onset of pain or problem: ❒ < 6 weeks ❒ 6-12 weeks ❒ 3 – 6 months ❒ > 6 months

Prior studies: ❒ MRI Date: ___/___/___ ❒ CT scan Date: ___/___/___ ❒ X-ray Date: ___/___/___

Location(s): ____

Previous consult/surgery: Date: ___/___/___ Provider: ____________________________________

Has the patient had previous treatment, such as injections/medications/physical therapy? Please list:

____

____

Preferred OA provider if applicable: ________________________________

***Complete when referring patient to Spine Center**

Back pain?	Yes ❒	No ❒	With leg pain Yes ❒	No ❒
Neck pain?	Yes ❒	No ❒	With arm pain Yes ❒	No ❒
Arm/Leg weakness?	Yes ❒	No ❒	left ❒	right ❒
Arm/Leg numbness?	Yes ❒	No ❒	left ❒	right ❒

****Please attach applicable notes/diagnostic studies if available****

Check if applicable:
Red Flags: ❒ bowel or bladder problems ❒ numbness in the groin or rectal area ❒ extreme weakness or numbness in feet or legs ❒ fever ❒ night sweats ❒ significant trauma ❒ weight loss

Referring Physician Signature: ____

Return form by fax to: ________________________ Fax#: ______________Ph#:____________
(Your Name) (Your Fax #) (Referring Office Phone #)

TO BE COMPLETED BY ORTHOPAEDIC ASSOCIATES

Appointment Date: ___/___/___ Time: __________ Provider: ______________________

Patient contacted? Yes No OA Account # (if established): ______________

Revised 041807